tient. I do not think we should compare surgery performed in Canada to that in developing countries.

In any setting we should try to provide the best possible care. I have ethical concerns about performing an inferior procedure with inferior results on the basis that it is better than no surgery at all.

K.G. Romanchuk, MD, FRCSC
Professor and head
Department of Ophthalmology (Eye Centre)
University of Saskatchewan
Saskatoon, Sask.

On attending a microsurgery course Dr. Loosmore discovered that he did not possess the skills to suture with hair-thin materials and tiny needles. He proposes that young women with steady hands and good eyes be trained to perform this delicate task.

These well-trained women exist. They are today's surgeons! Why should they be paid less than those who cannot perform such tasks?

History reveals the opposite. In many fields (e.g., ballet, hockey and even medicine) those possessing superior technical skills have been most highly prized and valued. Perhaps surgeons who cannot perform highly technical skills should receive less remuneration than those who can.

As for his view of ophthalmic surgery, Loosmore needs to visit an ophthalmologic operating room, where he would learn that "the standard eye operations" are indeed technically difficult and demanding. Modern ophthalmologists routinely use the materials and techniques Loosmore confesses he cannot. Fortunately Loosmore did not choose a career in ophthalmology; he would be unable to perform the essential skills and keep up with the rapid technologic change in the field.

Patients subjected to crude cataract procedures performed by the teenage children of missionaries have no choice. I suspect that Loosmore, like any other Canadian, would want highly technical and successful cataract surgery for his eyes. If he ever needs cataract or other ophthalmic surgery I urge him to consult a well-qualified ophthalmologist. Furthermore, he should spend less time musing about the value and practice of technically skilled surgeons and more time upgrading his skills to become more valuable to his patients.

Pamela Velos, MD, FRCSC
Weston, Ont.

It is curious that Dr. Loosmore, after experiencing difficulty in a microsurgical course, decided that intraocular surgery is not technically difficult and could be better performed by technicians.

Fortunately for Canadian patients, the modern cataract-removal technique of phacoemulsification does not resemble the procedures done in missionary camps. It requires a high level of technical skill and the identification and prevention of complications. The remarkable results are due more to the training and dedication of the surgeons than to the simplicity of the procedure.

It is disturbing that Loosmore's experiences of surgical problems and leaking anastomoses have led him to form such a low opinion of others' abilities. If he is genuinely concerned with advancing patient care he would be well advised to research his material before offering his theories for publication in a national journal.

Carl V. Jones, BM
Vancouver, BC

[The author responds:]

I apologize if my article offended anyone; causing offence was not my intention. It is disturbing that one small paragraph of the short, obviously tongue-in-cheek article gave rise to a sustained tirade.

I do not trivialize surgery, and I have the greatest admiration for ophthalmologists and their abilities. In response to Dr. Spencer, to suggest that a general surgeon should try to fashion a water-tight wound in eye tissue is absurd. As Dr. Jones indicates, I have experienced the distress of a leaking anastomosis: what honest general surgeon with 35 years' experience, much of it in developing countries, would claim otherwise? I admit that I cannot perform microsurgery to my satisfaction, but I did not say that some eye operations could be better performed by technicians.

My article was intended to consider who might best carry out fine surgery, not to recommend a particular group. The unpleasant overreaction has the hyperbole of a second-rate soap opera. Perhaps my article on robots in surgery should wait awhile.

Brian Loosmore, MB, FRCS
Drayton Valley, Alta.

Intrapartum penicillin prophylaxis of early-onset streptococcal infection

In their article "Effectiveness of intrapartum penicillin prophylaxis in preventing early-onset group B streptococcal infection: results of a meta-analysis" (*Can Med Assoc J* 1993; 149: 1659–1665) Upton D. Allen, MB, BS, Lissette Navas, MD, and Susan M. King, MD, CM, conclude that intrapartum penicillin prophylaxis in women whose birth canals are colonized by group B streptococci is effective in preventing early-onset neonatal disease. Although their methods appear appropriate, we have some concerns.

Through a similar search strategy we identified relevant meta-analyses[1–3] and randomized controlled trials (RCTs)[4–9] the authors did not consider. Three of the studies they included were duplicate publications. Studies by Tuppurainen and Hallman,[6,10] Boyer and Gotoff,[4,11] and Morales, Lim and Walsh[5,12] were published during the recruitment of subjects and at trial completion. Between the first[4] and second[11] publications of the study by Boyer and